Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: FMLA SPECIALIST @ PO BOX 970905 GREENSBORO, NC 27497-0905 FAX: 651-456-6041

Employee's job title: City Carrier Regular work schedule: 8:00AM - 4:30PM

Employee's essential job functions: Carrier case (sort) mail using repetitive motion. Carrier lift heavy tray & tubs of mail. Deliver letter, document & Parcel to Business and home. travel planned routes on foot or by Truck. Collect outgoing mail. etc.

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: WILLY J WONG EIN: 01197000
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Karl Bushman MD 2000 Oxford Drive #420 Bethel Park, PA 15102

Type of practice / Medical specialty: Internal Medicine

Telephone: (412) 942-8500 Fax: (412) 942-8519

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ~ 6/1/21

Probable duration of condition: Indefinite

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
✓ No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
6/18/21, 2/24/21, 1/6/21, 12/3/20, 12/1/20...

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ✓ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No ✓ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
✓ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓ No ___ Yes. If so, expected delivery date: ___

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No ✓ Yes.

If so, identify the job functions the employee is unable to perform:
Concentrate, do detailed work

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Patient has marked anxiety with shaking and palpitations in situations where he will encounter unusual stress at work related to interpersonal interaction with the people with whom conflict has occurred in the past.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ✓ No ___ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ✓ Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___ No ✓ Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   Occasional office visits

   Estimate the part-time or reduced work schedule the employee needs, if any:

   2 hour(s) per day; 1 days per week from now 8/27/21 through 8/27/21
   occasional

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___ No ✓ Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ___ No ✓ Yes. If so, explain:

   See above

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : 1 times per 1 week(s) _____ month(s)

Duration: 0-8 hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

See above.

Signature of Health Care Provider

9/10/21
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Complete the **PO Box number** and **Zip +4 Code** on front before mailing.

Mail only the **completed Certification** form to HRSSC.

UNITED STATES POSTAL SERVICE

HRSSC - FMLA
PO Box 970900
Greensboro, NC 27497-0900

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DO NOT ADD SPECIAL SERVICES

FMLA Specialist – HRSSC – FMLA

PO BOX 970905

GREENSBORO NC 27497- 0905

7530-17-000-0670